DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 09-65-A	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE December 1, 2009	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447.204**	7. FEDERAL BUDGET IMPACT: **a. FFY 12/1/09 – 9/30/10 $42,856** **b. FFY 10/1/10 – 9/30/11 $ 47,436**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 1(e)(1), 1(e)(2), 1(e)(2.1), 1(e)(3), 1(f), 1(g), 1(g)(1), 1(h), 1(h)(1), 1(h)(2), 1(i), 1(j), 1(j)(i), 1(l), 1(l)(i), 1(l)(ii)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 1(e)(1), 1(e)(2), 1(e)(3), 1(f), 1(g), 1(h), 1(i), 1(j), 1(j)(i), 1(l), 1(l)(i)**

10. SUBJECT OF AMENDMENT:
Revisions to Hospital Based APGs
FMAP: 61.59% for 12/1/09 – 12/31/10; 58.77% for 1/1/11 – 3/31/11; 56.88% for 4/1/11 – 6/30/11; 50% 7/1/11 and after

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: January 3, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **February 6, 2013**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **December 1, 2009**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: **Ricardo Holligan**	22. TITLE: **Acting Associate Regional Administrator** **Division of Medicaid and State Operations**

23. REMARKS: